

## CLIENT REPORT CARE/HIPP

Client name (last) (First) (MI)	Date of Birth (MM/DD/YY)	Enrollment Date (MM/DD/YY)
Residence (Street)	(City)	(County) (Zip)

### Race/Ethnicity (check all that apply)

- ☐ White, non-Hispanic
- ☐ African-American (non-Hispanic)
- ☐ African-American/Black
- ☐ Caribbean, not Puerto Rican or Cuban
- ☐ African/Black
- ☐ Hispanic/Latino
- ☐ Mexican/Mexican-American
- ☐ Cuban
- ☐ Puerto Rican
- ☐ Central American
- ☐ South American
- ☐ Spanish
- ☐ Other \_\_\_\_\_
- ☐ Asian/Pacific Islander
- ☐ East Asian
- ☐ South Asian
- ☐ Southeast Asian
- ☐ Pacific Islander
- ☐ Other \_\_\_\_\_
- ☐ American Indian, Aleutian, Native Alaskan, Eskimo
- ☐ Unknown or declined

### Gender (client identification)

- ☐ Male
- ☐ Female
- ☐ Transgender Male to Female
- ☐ Transgender Female to Male
- ☐ Other \_\_\_\_\_
- ☐ Declined

### Receiving public assistance other than Medi-cal (check all that apply)

- ☐ SSI
- ☐ TANF
- ☐ SSDI
- ☐ SDI
- ☐ General Assistance
- ☐ Other \_\_\_\_\_

### Client Status

- ☐ Active
- ☐ Inactive date \_\_\_\_\_

### Reason for Inactivity

- |   |  |
|---|--|
| <input type="checkbox"/> Moved out of state     | <input type="checkbox"/> Cobra exhausted   |
| <input type="checkbox"/> Transition to HIPP     | <input type="checkbox"/> Obra exhausted    |
| <input type="checkbox"/> Transition to Medi-Cal | <input type="checkbox"/> Lost to follow-up |
| <input type="checkbox"/> Returned to work       | <input type="checkbox"/> Death             |
| <input type="checkbox"/> 29 months exhausted    | <input type="checkbox"/> Coverage lost     |
| <input type="checkbox"/> Other _____            |  |